ANZSPM

Essential palliative & end-of-life care in the COVID-19 pandemic

IMPORTANT PRINCIPLES

- **GOALS OF CARE** must be discussed early including the decision NOT to escalate to ICU/intubation/ resuscitation.
- **FREQUENT COMMUNICATION** with families is crucial
- Be prepared to **ESCALATE** symptom management to prioritise comfort (unmanaged symptoms add distress to patients, families and staff). **REMEMBER** physical, psychosocial and spiritual care needs.
- If first-line medications listed here are not available, **REFER** to ANZSPM "Specialist palliative care in the COVID-19 pandemic" document for alternatives [*Available soon*].

ANTICIPATORY PRESCRIBING

- PRE-EMPTIVE: Prescribe anticipatory medications when goals of care agreed on (chart one medication for each of the below symptoms).
- Start with PRN, if using >4 PRNs in 24h, regular dosing should be commenced AND PRN continued.
- The following are STARTING DOSES ONLY. Doses may need titration depending on symptom severity.
- > 4 PRN in 24h should prompt review and dose adjustment.
- PRN usage and syringe driver doses should be reviewed every 24h.

For dyspnoea or pain or cough

For opioid naïve patients: MORPHINE subcut 2.5-5mg 1-hourly PRN.
If eGFR<30ml/min: HYDROMORPHONE* subcut 0.5-1mg 1-hourly PRN.
If regular dosing required: MORPHINE subcut 10mg over 24h via syringe driver (if not available, give regular MORPHINE 2.5mg subcut 4-hourly).
If eGFR<30ml/min: HYDROMORPHONE* 2mg over 24h via syringe driver.
If on regular opioids and still symptomatic: consult specialist palliative care team regarding dose escalation and opioid conversion.
*HYDROMORPHONE is approx. 5 times more POTENT than morphine. Some states such as NSW recommend prescribing by specialists in palliative care and pain management.

For severe dyspnoea or agitation

MIDAZOLAM subcut 2.5-5mg 1-hourly PRN.
If regular dosing required: MORPHINE subcut 10mg PLUS MIDAZOLAM subcut 10mg via syringe driver over 24h.

For nausea and vomiting

METOCLOPRAMIDE 10mg subcut 4-hourly PRN
In Parkinson's Disease: use CYCLIZINE subcut 25mg 4-hourly PRN (max 100mg/24h).

For respiratory secretions

GLYCOPYRROLATE subcut 0.4mg 4-hourly PRN.
If regular dosing required: GLYCOPYRROLATE subcut 1.2mg over 24h.

Fever: Paracetamol PO or IV. **AVOID NSAIDs**.

Mouthcare: Sodium bicarbonate 1% mouthwash 10ml 6-hourly AND topical lanolin to lips 6-hourly.
Bowel care: Glycerine and Bisacodyl suppositories PR every 3 days if bowel not opened. If ineffective prescribe fleet enema.

THESE GUIDELINES SHOULD BE ADAPTED DEPENDING ON LOCAL PROTOCOL AND DRUG AVAILABILITIES. For further assistance, please contact THE PALLIATIVE CARE TEAM on _____.

Non-pharmacological management of dyspnoea

- Trial of low-flow oxygen via nasal prongs if hypoxic.
- Cool the face using flannel or cloth.
- Sit upright and lean forward if possible.
- AVOID fans and nebulised medications due potential infection risk.
- Re-positioning in bed may help with secretions.

For severe dyspnoea in a dying patient

MORPHINE subcut 5mg PLUS MIDAZOLAM subcut 5mg every 15mins until comfort achieved

Communication tips

Visiting "I wish I could let you visit, because I know it's important, but it's not possible right now".

Name emotion "This is an awful situation. I think anyone would feel scared/anxious/angry."

Be honest "I worry time could be short."

Non-abandonment AVOID saying "there's nothing more we can do" and INSTEAD say "we will do everything possible to make sure your … is comfortable no matter what happens".

Engage families "is there anything we need to know about him/her to help us care for him/her?"

NOTICE: This **ANZSPM guidance document** has been prepared by the ANZSPM COVID-19 Special Interest Group. It is subject to regular review and revision in response to the changing COVID-19 environment. Check anzspm.org.au for updates and speak to your local Palliative Care Team.